

**Vermont Alcohol and Drug Abuse
Advisory Council**

Department of Liquor Control
13 Green Mountain Drive
Montpelier, Vermont

Wednesday, April 24th, 2013
10:00AM – 12:00PM

I. Welcome and Introductions

Welcome

Welcome everyone

Introductions

Barbara Cimaglio
Lauren Fisk
Mark Depman
Andy Snyder
Patrick Martin
John Gramuglia
Chauncey Liese
Steve Waldo
Joy Mitchell

Regrets

Patty McCarthy Metcalf
Willa Farrell
Michael Macarilla
Ryan Mitofsky
Lori Augustyniak
Mark Ames
Mitch Barron
Mourning Fox

II. Approval of Minutes: March 27th, 2013

March 27th – Minutes approved with the following changes – No Changes Needed

III. Deputy Commissioner Report: Barbara Cimaglio

Program Updates –

Language around structure of council –
Still working on this.

Marijuana Bill -

We are not sure where this is going right now. Chauncey has concerns around license suspension regarding this. Where does the licensure suspension piece fall? Willa would have more information on this. This is being modeled a lot after the Teen Alcohol Safety Program. One of the key components of this program is that license suspension will occur. We will have more on this subject at a later meeting.

Alcohol Awareness Month -

April is Alcohol Awareness Month. Prevention Day is tomorrow, April 25th, at the state house. VDH has a press release out that is highlighting the www.ParentUpVT.org website which is related to parents talking to their children about alcohol. There are a lot of resources on the website that can help parents understand the laws and the health risks around early use of alcohol. Barbara will be on the 30 tonight with Kristin Carlson promoting Alcohol Awareness Month. A lot of our coalitions throughout the state are doing activities to promote Alcohol Awareness Month.

Legislation –

The VPMS Legislation has gotten very complex. It started with adding the ability for us to share our data with other states and adding some different elements of requirements for physicians, requiring them to register, and to have to check VPMS in certain circumstances. They put the opioid overdose pieces in with the bill. This will now direct the department to create an opioid overdose prevention program using Narcan. Other states like Massachusetts and New York have well developed programs that are linked with opioid treatment centers, or needle exchange programs, and other places where there might be opioid users. They are able to distribute Narcan to families and associates of persons who might be at risk for overdose. The legislature around this started in the house, and the house judiciary committee is very concerned about the number of overdoses in the state and people being afraid to call law enforcement for fear of prosecution, so the committee has also changed some statute so that if a person is calling for help related to a life threatening situation from overdose, the person calling will not be prosecuted. This is called the “Good Samaritan Clause”. This language is in H522.

The Agency of Education and the Department of Health are doing a survey of schools to see what they are currently doing with prevention education for substance abuse and to work toward making sure they are within the health education standards. The language is still being worked on. The Department of Health contributed some changes and worked with the Agency of Education.

During the off years, when VDH is not doing the YRBS, AOE was doing the school health survey. VDH will be doing the school health survey now. It will cover the issue of what we need to know. This survey is not for the students. It is more around the policy and what the schools are doing in their curriculum and what their teacher training is.

Hub and Spoke –

Rutland Hospital will be developing a clinic in the fall. Grants will be executed in July for Central and Southeastern Vermont to begin Opiate Treatment Hubs.

Secretary Racine asked Barbara to work with him on looking at how we are addressing Substance Abuse across the Agency of Human Services in a more conservative way. We have begun an internal process. The Secretary is concerned that there are a lot of different

initiatives happening across the Agency. He wants to make sure that the approach is evidence based, and connected.

IV. Special Guest – Beth Tanzman – Blueprint for Health

Blueprint for Health – Hub and Spoke – Handout

The Blueprint for Health is part of Vermont's health care reform initiative. It is about reforming the service delivery, and trying to build the kind of health care system that Vermonters want to have or purchase. This began with a focus on primary care. There are 2 reasons why the focus is on Primary Care. The first is that Primary care is under resourced. The second is that when we look at the biggest drivers to Vermont's National Health Care expenditures, the management of chronic illnesses contributes greatly to our overall health care costs and can also contribute to poor health outcomes for the population. In addition, the ability to identify earlier on and intervene and support patients before they become chronically ill is critical to bending the cost curve. The service delivery reform effort that began first in Vermont really focused on how to better resource and provide primary care services in Vermont. It is built off of a series of policy development standards in major medical academies that cover primary care. These standards said that if we created something called a patient centered medical home, we would be better able to deliver more robust care. The characteristics of a patient centered medical home are the ability to track and manage populations of patients, the ability to outreach and get to people in advance of them visiting the physician, and also by team based care and involving other disciplines. What we did in Vermont is unique, in that, this initiative is "all payer". Vermont did a classic return on investment model which says, what resources would primary care in Vermont need to have to function as a patient centered medical home and how much would that cost us? How do we bend the cost curve enough to convince Vermont's major payers to participate? Vermont developed a concept of helping primary care practices make the transformation to being a patient centered medical homes, and giving them the opportunity to work with inter-disciplinary teams. They also needed a health information technology around implementing the electronic medical records, and how they would use those records to help secure patient population management. Refer to diagram on page 3 of handout around Fee for Service. Fee for service tends to reward volume. The more patient encounters a provider has, the more you can bill for them. It also supports competition and also promotes more encounters. Vermont added a concept that if you meet the nationally established medical home standards, all payers will share and give you an extra payment. The payment will change based on how high the score was against those standards. Right now in Vermont we have around 180 primary care practices. This is a moving target. Out of those primary care practices, 110 current meet the standards of patient centered medical homes. Collectively those practices are serving about 440,000 Vermonters. This is very well spread out throughout the state. The percentage of the population covered in a primary care practice is significantly lower in Brattleboro.

The second payment reform is, all of the payers agree to jointly pay for a Community Health Team. Those teams can work with a primary care practice to work on things such as diabetes education, motivational interviewing to change substance abuse or other psycho-social issues. The Community Health Teams are equally paid for by Blue Cross Blue Shield, MVP, Cigna, Medicaid and Medicare. They are provided free of charge to the primary care practices, and free of any charge or co-pay to the patients. They are planned locally. They are scaled based on the size of the population who is actively being seen by the participating primary care practice. This provides about \$300,000 per \$20,000 Vermonters. With that money, Vermont tries to buy as much as 5 FTE's. The typical Community Health Team would include a Nurse Care Coordinator, Health Coach and a Social Worker.

We currently have a little over 100 FTE CHT staff in place statewide now with the associated patient centered medical homes. The amount of change that the CHT staff is driving locally in the practices is phenomenal. The payment reform aspect is that, the staff is there and available to the community, providers, and patients, without anyone having to bill a single episode of care. Primary care practices see a lot of patients with substance abuse or mental health issues. These patients may first go to primary care, but many of them never make it into any of our mental health/substance abuse specialized treatment systems. A few of the reasons for this is stigma and also in many environments, those services are not equally covered under the insurance. Patients may need prior authorization or only be able to get into certain networks. If primary care practices were to systematically identify and screen and do brief intervention around patients with mental health or substance abuse conditions, is there enough network capacity for primary care practices to refer people out who need more of an assessment or more intensive treatment? Where are some smart investments that we can make within primary care and community health teams to strengthen their capacity to identify and manage the basic mental health and substance abuse conditions? What kind of investments could we make that collaborate with a specialty network to provide more intensive treatment to patients who have mental health and substance abuse conditions?

Our first major step into this is the Hub and Spoke initiative. This initiative has all of the advantages and disadvantages being focused out of a particular population. Although Tobacco and alcohol are bigger contributors to health issues in Vermont, there has been a lot of attention paid to the issue of opioid dependence which is causing some issues in our medical community. This is in part because the abuse of prescription medications has overtaken heroin as the leading cause of opioid dependence. We have seen an increasing trajectory of people becoming opioid dependent and seeking treatment, and then not being able to treat them because we didn't have that capacity in our treatment networks. Because of a major piece of federal legislation that passed in 2000, primary care and other outpatient physicians had received the authority to prescribe buprenorphine and suboxone. Our thinking was that management of addiction conditions is part of primary care and it is reasonable that it can be managed in the primary office. In Vermont we saw a rapid rise in number of Medicaid beneficiaries getting that treatment, and also a rapid rise in the number of physicians who were prescribing. Vermont is currently working with 13 practices on the learning collaborative. We began this collaborative with looking at what the strength of the evidence and documentation of opioid dependence in the clinical record of patients with a buprenorphine prescription is. This is a very complex area of medicine. Because there was a lot of attention around opioid dependence, the team at DVHA, and ADAP looked at, if this is where the energy is, we need to build something out that works for that population, but also puts in footprints in place around addictions management across specialty systems management and primary care. 170 physicians are currently prescribing. These physicians are in primary care, pediatrics, OBGYN, specialty psychiatry etc... Our methadone programs are geographically in a few specialized centers. We decided to create a concept of beefing up these centers to be able to not only provide addictions treatment or methadone treatment, but also to be in a consultative reciprocal referral arrangement with a broader medical community. Physicians who were prescribing suboxone were saying that if they knew that they could call up an addictions doctor and get a work-up and a consult on a patient, then they are willing to try. The specialized methadone programs have a need for people who are stable in their recovery, to be able to get them back out into the ongoing care network. There needs to be a dynamic relationship between those parts of the system.

We are taking advantage of a part of the Affordable Care Act, Section 2703, which sets up Health Home which was meant to mirror the patient centered medical homes, but it allows states to amend their Medicaid plans to provide services that were not previously matched to Medicaid.

The goal is to have a more linked approach where the initial screening would be done in primary care. If the patient needs a more in depth intervention, it could be embedded in the practice or in agreement with a mental health/substance abuse provider. There is a lot of room for different models depending on what the resources are in the community. We hope to enhance the connections between providers. There is not a good focus on gambling addictions in primary care. There are evidence based questions around gambling, but another important piece is to look at how gambling is contributing to a person's health (stress, heart problems, stomach problems etc...).

If you have any materials that would be useful to Beth, please email them to her at beth.tanzman@state.vt.us and she will distribute them to the Community Health Teams. What is being looked at to deal with the criminal aspect of suboxone? ADAP in cooperation with DVHA has written a series of regulations for physicians around the standard of practice around medication assisted treatment. Any physician who is serving over 30 patients in their practice with medication assisted treatment has to meet those standards. If someone believes that the physician is not meeting those standards, that may be reported to the Medical Practice Board.

We are working with a group of practices who have agreed to do consistent measurement around core care processes that are designed to help reduce the risks of diversion happening in their practice. Examples are consistent use of VPMS and supporting practices in developing better systems of randomized urine analysis.

DVHA has requirements for patients on Medicaid which helps to ensure that they are following their treatment, and that they are not doctor shopping, or going to different pharmacies.

The current focus on patient centered medical homes has been Diabetes, Hypertension, Asthma, Coronary Artery disease. The National Council of Quality Assurance standards for patient centered medical homes change every three years. The last change of these standards required practices to pick three clinically prominent conditions based on the amount of population in their patient's panel who have those conditions. The conditions chosen have to be prevalent in their practice. The practices must meet a series of standards on those three conditions. The standards also required that at least one of those conditions be a behavioral health condition. Many practices have been choosing suboxone, depression, obesity and tobacco cessation.

V. Future Guests

Brian Reamer – Suicide Prevention U Matter – Invite to a future meeting
Ena Backus – Green Mountain Care Board
Patty Baroudi – College Initiative
Charlie Biss – Children's Mental Health

VI. Member Reports/Announcements

Andy Snyder – The presentation done by Shayla Livingston last meeting on the Youth Risk Behavior Survey was great. The questions were right to the point and she answered them fluently.

Barbara Cimaglio – Dr. Chen is at the legislature this morning. It looks like legislature will accept the language for the council statute.

Handout from Steve Waldo – Youth Alcohol Brand Survey

Handout from Joy Mitchell – National Council on Problem Gambling Pamphlet

Patrick Martin – When Wits end started it was based around drugs. Now more and more people are coming in with issues around alcohol. Also, the use of ridelin and aderol in school is rising. It is helping students as a study aide.

Chauncey Liese – Vermont currently has about 400 drivers that are currently using an Ignition Interlock Device. 30-40 people who have served their time with the Ignition Interlock device and graduated to a non-restricted driver's license. Only one repeat offense out of those.

NEXT MEETING: Wednesday May 22nd – Updates around alcohol.